Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

For: The University of California

Group Policy No.: GP-724666

Effective Date: As of the dates shown below

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the dates shown below.

Effective October 1, 2001, the following changes have been made to your Booklet-Certificate:

1)The following section is added to the Comprehensive Medical Expense Coverage section:

Contraception Expenses

Covered Medical Expenses include:

- charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:

  consultations;
  exams;
  procedures; and
  other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

2) The following definition replaces the definition under the same title in the Glossary:

Prescription Drugs

Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

Effective January 1, 2002, the Separate Brand Name Fee described in the Prescription Drug Expense Coverage section of your Booklet-Certificate no longer applies. You will be required to pay only the applicable copay per Prescription or Refill shown in your Summary of Coverage.

President and Chief Executive Officer

Rider: 2
Issue Date: November 1, 2001

UC Care Out-of-Area Plan

Summary of Coverage

For: The University of California

Group Policy: GP-724666

SOC: 1A

Issue Date: November 1, 2001

Effective Date: January 1, 2002

Employee:

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

This is an electronic version of the Summary of Coverage on file with your Employer and Aetna Life Insurance Company, Hartford, CT. In case of a discrepancy between this electronic version and the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth by such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Employees and Dependents (Eligible Class)

Please refer to the separate amendment (Rider 1) for a complete description of employee and dependent eligibility.

Enrollment Procedure

Please refer to the separate amendment (Rider 1) for more information about the enrollment procedures. Additional information follows this Summary of Coverage.

Effective Date of Coverage

Employees and Dependents

Please refer to the separate amendment (Rider 1) for a complete description of when employee and dependent coverage becomes effective.

Health Expense Coverage

Employees and Dependents

Your Booklet-Certificate spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet-Certificate for a complete description of the benefits payable.

Prescription Drug Expense Coverage

Prescription Drug Benefits

Calendar Year Deductible	$ 50 per person
Family Deductible Limit	$ 150 per calendar year

The Calendar Year Deductible applies to all Covered Prescription Drug Expenses for prescription drugs dispensed by a Non-Preferred Pharmacy.

Payment Percentage
100% as to:

Preferred Pharmacy	Copay per Prescription or Refill	
	Supply of up to 30 days	Mail Order Drug Supply of over 30 days*
Brand Name Drugs		
On Medication Formulary	$ 25	$ 50
Not on Medication Formulary	$ 40	$ 80
Generic Drugs	$ 15	$ 30

* but no more than a ninety (90) day maximum supply.

90% as to:

Non-Preferred Pharmacy (after the Calendar Year Deductible)

NOTE: Diabetic supplies and self-injectible drugs are covered at no charge when obtained from a Preferred Pharmacy. The copay amounts and Calendar Year Deductible shown above do not apply to these items.

A list of drugs requiring certification is included in your Booklet-Certificate. This list is subject to change by the Plan. An updated copy of the list of drugs requiring certification is available on request.

Comprehensive Medical Expense Coverage

Certification Requirement

If you or one of your dependents require confinement in a hospital:

Days in the hospital must be certified if full plan benefits are to be available.

As soon as you or one of your dependents know confinement will be required, read the Comprehensive Medical Expense Coverage section of the Booklet-Certificate for details on how to get the certification.

Non-Certification for Hospital Admissions	
Excluded Amount	$ 200

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet-Certificate.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

NOTE: This Plan's Calendar Year Deductibles, Coinsurance Limits and Calendar Year and Lifetime Benefit Maximums are combined for members who transfer between in-area and out-of-area status.

Deductible Amounts

Calendar Year Deductible	$ 250 per person

The Calendar Year Deductible applies to all Covered Medical Expenses except:

Convalescent Facility Expenses
Home Health Care Expenses
Hospice Care Expenses
Preventive Health Care Services Expenses
Routine Physical Exam Expenses
Routine Cancer Screening Expenses
National Medical Excellence Travel and Lodging Expenses
Expenses authorized under the Healthy Outlook Program

Family Deductible Limit	$ 750 per calendar year
Hospital Emergency Room Deductible	$ 75 per visit

This Hospital Emergency Room Deductible applies to all Hospital Expenses for emergency room care. It is waived if the person is admitted to a hospital as an inpatient within twenty-four (24) hours after a visit to a hospital emergency room.

Payment Percentage

For Other Covered Medical Expenses
100% up to plan maximums as to:

National Medical Excellence Travel and Lodging Expenses
Expenses authorized under the Healthy Outlook Program

90% up to plan maximums as to:

Hospital Expenses
Convalescent Facility Expenses
Home Health Care Expenses
Hospice Care Expenses
Preventive Health Care Services Expenses
Routine Physical Exam Expenses
Routine Hearing Care Expenses (exams only)
Short Term Rehabilitation Expenses
Spinal Disorder Treatment (including Chiropractic) Expenses
Acupuncture Expenses
Other Covered Medical Expenses for which a Payment Percentage is not otherwise shown (see your Booklet-Certificate for details)

50% as to:

Routine Hearing Care Expenses (hearing aids only)

Payment Limits

These limits apply to all Covered Medical Expenses except expenses applied against the Hospital Emergency Room Deductible.

Payment Limit which Applies to Expenses for a Person
When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage (including expenses applied against the Calendar Year Deductible) reach $ 3,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Payment Limit which Applies to Expenses for a Family
When a family's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage (including expenses applied against the Family Deductible Limit) reach $ 9,000 in a calendar year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Benefit Maximums

(Read the coverage section in your Booklet Certificate for a complete description of the benefits available.)

Convalescent Facility Maximum Days	Two-hundred forty (240) per calendar year
Home Health Care Maximum Visits	One-hundred (100) per calendar year
Hospice Care Lifetime Maximum	$ 10,000

Routine Hearing Care	
Hearing Aid Maximum	$ 2,000 per thirty-six (36) months (one hearing aid per ear)
Private Duty Nursing Care	
Maximum Shifts	Seventy (70) per calendar year
Acupuncture Expenses Maximum	$ 500 per calendar year
National Medical Excellence	
Lodging Expenses Maximum	$ 50.00 per night
Travel and Lodging Maximum	$ 10,000 per episode of care
Private Room Limit	The institution's semiprivate rate.
Lifetime Maximum Benefit	$ 2,000,000 per person
Restoration Amount	$ 1,000 per year

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the person's coverage ceases due to discontinuance of the group contract as to the coverage, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29.

KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET-CERTIFICATE

Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the

Consumer Service Division
Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Additional Information Provided by The University of California

The following information is not a part of your Booklet-Certificate. In furnishing this information, Aetna is acting on behalf of the University.

Additional Information Regarding Eligibility, Enrollment and Termination of Coverage

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are an Annuitant, contact the University's Customer Service Center. Enrollment transactions may be by paper form or electronic, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

If you are in an HMO and you move or are transferred out of that HMO's service area, or will be away from the HMO's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the HMO's service area.

In-Area Eligibility
You are eligible for in-area benefits if you are an eligible Employee or Annuitant permanently living inside the California HMO Service Area (Tier 1 service area). These benefits are explained in a separate booklet.

Change in Coverage
In order to change from individual to two-party coverage and from two-party to family coverage, or to add another Family Member to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

Additional Information Regarding Effect of Medicare on Annuitant Enrollment
Annuitants and their Family Members who are eligible for premium free Medicare Part A, but decline to enroll in Part B of Medicare, will be assessed a monthly offset fee by the University to cover increased costs. Annuitants or Family Members who are not eligible for Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Affidavits may be obtained from the University's Customer Service Center. (Annuitants/Family Members who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration forms are available through the University's Customer Service Center. Completed forms should be returned to the Annuitant Insurance unit at Office of the President.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the UCbencom website (www.ucop.edu/bencom). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are an Annuitant.

Plan Administration

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. All of the terms and conditions in your Booklet-Certificate, including but not limited to eligibility and enrollment requirements, must be met in order to be entitled to benefits. Particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in your Booklet-Certificate. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th Floor
Oakland, California 94612-3557
(800) 888-8267

Annuitants may also direct questions to the University's Customer Service Center at the above phone number.

The Plan is administered through a group insurance policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Claims under the Plan are processed by Aetna Life Insurance Company at the following address:

Aetna U.S. Healthcare
P.O. Box 9220
Van Nuys, CA 91410-0220
800-632-0524

Group Policy Number
GP-724666

Type of Plan
This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year
The plan year is January 1 through December 31.

Continuation of the Plan
The University of California intends to continue the Plan of benefits described in your Booklet-Certificate but reserves the right to terminate or amend it at any time. The Plan is not a vested plan. The right to terminate or amend applies to all Employees, Annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

Financial Arrangements
The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process
Legal process may be served on the Plan Administrator or on any of the plan claim processors at the applicable address listed above.

Your Rights under the Plan
As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including insurance contracts.

- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan
Your Booklet-Certificate contains information on reporting claims. Claim forms may be obtained by calling Aetna Member Services at 1-800-632-0524. These forms tell you how and when to file a claim.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

You may request a review of the denied claim. The request must be submitted, in writing, within sixty (60) days after you receive the notice. Include your reasons for requesting

the review. Submit your request to the office of the Aetna Life Insurance Company to which you submitted your initial request for benefit payment.

Aetna will review your claim and ordinarily notify you of its final decision within sixty (60) days of receipt of your request. If special circumstances require an extension of time, you will be notified of such extension during the sixty (60) days following receipt of your request.

Nondiscrimination Statement
In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director Mattie Williams and for faculty to Executive Director Sheila O'Rourke, both at this address: University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your ID card.